U.S. Health Reform—Monitoring and Impact

Is There Potential for a Public Option to Reduce Premiums of Competing Insurers?

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011. The Urban Institute documents changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

INTRODUCTION

There is considerable interest in making a public option available in the Affordable Care Act (ACA) nongroup marketplaces. Setting provider payment rates at or close to Medicare's would presumably lower marketplace premiums, particularly in high-priced markets. As we have suggested elsewhere, a public option could catalyze competition in less competitive markets, leading other marketplace insurers to lower their premiums.[1] The lower rates paid by a public option could give insurers more bargaining power over hospitals and physician groups with market control, and exerting that bargaining power would be critical to private insurers retaining significant market share. Providers could therefore accept lower payment rates, given the threat that a public option would dominate, and insurers could then offer lower premiums.

A public option paying rates similar to traditional Medicare rates could offer coverage with premiums lower than those of insurers who pay commercial rates. Thus, many commercial insurers resist this reform, believing they cannot compete. Evidence showing insurers would respond with somewhat lower rates and continue to compete with a Medicaid insurer could inform the conversation about the implications of introducing a public option. Thus, we analyze commercial insurers' experiences competing in marketplaces with managed-care organizations, which, before ACA implementation, only offered coverage within public programs (either Medicaid only or Medicaid and Medicare). These managed-care organizations, though not purely public options, represent a proxy for them. For their marketplace business, most of these organizations seem to have built upon their existing Medicaid networks, allowing them to offer lower-cost provider networks, albeit at rates somewhat higher than those paid under Medicaid. These organizations likely pay providers something closer to Medicare rates for their marketplace business, rates which are generally well below commercial rates.[2]

Our central results are as follows:

- Rating regions with more participating insurers have lower benchmark (second-lowest silver) premiums in 2019, consistent with our findings in previous years. In 2019, rating regions with only one marketplace-participating insurer are associated with benchmark premiums for a 40-year-old about $230 higher per month than those in a rating region with five or more marketplace insurers.
- In 2019, rating regions with a previously Medicaid- or Medicaid/Medicare-only insurer (herein called Medicaid insurers) participating are associated with benchmark premiums for a 40-year-old about $30 per month lower than in comparable rating regions without a participating Medicaid insurer.
- In rating regions with a Medicaid insurer participating in the marketplace in 2019, a Medicaid insurer offers the lowest-priced silver plan 72 percent of the time.
- When analyzing only the lowest marketplace premium offered by each non-Medicaid insurer, we find having at least one Medicaid insurer as a competitor is associated with a $38 lower premium per month for a 40-year-old. This represents a premium about 7 percent lower than the average non-Medicaid insurer's lowest-priced option.

DATA AND METHODS

Data on 2019 premiums come from the healthcare.gov federally facilitated marketplace public use files and from individual state-based marketplace websites. Data on hospital concentration comes from the 2015 American Hospital Association Annual Survey Database. The average wage index also uses data from the Centers for Medicare & Medicaid Services. We use the core-based statistical area data provided by the Centers for Medicare & Medicaid Services and calculate the weighted average at the rating area level using county populations from the Census Bureau.

We estimate two linear regression models. The first model uses the premium rating region as the unit of observation with the dependent variable equaling the monthly benchmark premium for a single policy for a 40-year-old nonsmoker in 2019. The second model uses insurers at the premium rating region level as the unit of observation, limiting observations to non-Medicaid insurers only. The dependent variable in the second regression is the premium of the lowest-priced silver option for a 40-year-old nonsmoker each insurer offers in each ACA rating region for the 2019 plan year. The key independent variable is whether a Medicaid plan offers marketplace coverage in 2019 in that rating region. We also control for several factors in both regressions:

1. Pure community rating. This is a binary variable equal to one in New York and Vermont, states with pure community rating (no age variation) in their private nongroup insurance markets. This variable accounts for premiums in those states, reflecting the costs associated with the average enrollee across all ages, not for a 40-year-old, as is the case in all other states.

2. Rating region population. We control for the size of the rating region, assuming larger rating regions may be more competitive and lead to lower insurer premiums, regardless of whether Medicaid insurers participate.

3. Urban area. In previous work, we have shown premiums in urban areas tend to be measurably lower than those in rural areas.[3] Once we simultaneously control for wage levels, rural areas still have somewhat higher premiums because they generally have less insurer and hospital competition.

4. Hospital concentration. We use three dummy variables to control for hospital concentration: Herfindahl-Hirschman Indices (HHIs) of 2,501–5,000; 5,001–7,500; and 7,501–10,000.[4] Rating areas with HHIs of 2,500 or less (the most competitive markets) are the left-out category. Higher market concentration implies greater difficulty for insurers to negotiate lower provider payment rates, implying greater concentration should result in higher premiums, all else being equal.

5. The number of insurers. As we have shown elsewhere and confirm here for 2019, as the number of marketplace-participating insurers increases in a rating region, premiums tend to decrease.[3,5]

6. Insurer type. We use these dummy variables in the first regression to indicate whether at least one marketplace insurer in the rating region is a given insurer type. We define Blue Cross Blue Shield insurers as members of the Blue Cross Blue Shield Association. Co-ops, established under the ACA, are enumerated on the National Alliance of State Health Co-Ops website. Medicaid insurers only offered public insurance plans (Medicaid with or without Medicare) before the 2014 nongroup open enrollment period. Provider-sponsored insurers are directly affiliated with a provider group (usually a hospital system). Regional insurers offer commercial insurance but are generally limited to specific states or geographic regions. National insurers offer commercial insurance across broad geographic areas.

7. Census region. We use these to control for geographic variation. The Midwest is the left-out category.

8. Average wage index. We control for average wages because higher-labor-cost areas are expected to have higher premiums, given that medical care is a labor-intensive good.

9. Federally facilitated marketplace. This dummy variable equals one if the marketplaces in the state are run by the federal government. States running their own ACA marketplaces (state-based marketplaces) may have different experiences because of different enrollment rates and other regulatory approaches.

10. State that expanded Medicaid by 2018. This dummy variable equals one if the insurer (or rating region, depending on the regression) is located in a state that expanded Medicaid eligibility under the ACA by 2018 for all residents with incomes up to 138 percent of the federal poverty level.

These regression models provide a correlation between the presence of a Medicaid plan and premiums for competing marketplace insurers. They are not interpreted as proving causation, though they suggest causation, as we note below.

FINDINGS

All premiums presented are monthly and apply to a 40-year-old. Table 1 provides the average 2019 benchmark (second-lowest priced silver) single premium across all 502 ACA nongroup market rating regions and separately for the rating areas with and without a participating Medicaid insurer.[6] The average benchmark premium in rating areas with a Medicaid insurer is $124.58 (21.9 percent) lower than the average in rating areas without a competing Medicaid insurer. However, other characteristics differ between the rating areas with and without Medicaid insurer participation. Rating areas with a Medicaid insurer are more likely to be in states that have expanded Medicaid eligibility under the ACA and have larger populations on average and are noticeably less likely to have only one insurer offering marketplace coverage.

In the regression of 2019 benchmark premiums on the participation of at least one Medicaid insurer in the marketplace rating region, we control for other rating region characteristics that may correlate with the presence of a Medicaid insurer (Table 2). Consistent with earlier analyses, we find an association between the presence of a Medicaid insurer in a rating region and significantly lower benchmark premiums. In 2019, holding other rating region characteristics constant, rating regions with participating Medicaid insurers had benchmark premiums $29.86 per month lower, on average. In contrast, the presence of a Blue Cross Blue Shield–affiliated plan, provider-sponsored insurers, and regional insurers are associated with higher benchmark premiums.

In addition, urban areas are associated with benchmark premiums $29.85 per month lower, on average, than those in rural areas. As the number of insurers increases, premiums tend to decrease; thus, rating areas with only one insurer are associated with benchmark premiums $230.54 more expensive, on average, than benchmarks in similar areas with five or more marketplace insurers. Likewise, benchmark premiums also tend to be higher in rating regions with two, three, or four insurers than those in areas with five or more insurers; the size of the premium difference decreases as the number of insurers increases. Benchmark premiums in states that expanded Medicaid eligibility are, on average, about $63 per month lower than those in nonexpansion states, holding other rating region characteristics constant. In addition, monthly benchmark premiums are, on average, $90.50 higher in federally facilitated marketplace rating regions than in state-based marketplace rating regions.

In addition to the strong negative relationship between Medicaid insurer participation and benchmark premiums shown in the regression, when at least one Medicaid insurer participates in a marketplace rating area, a Medicaid plan is the lowest-priced option 72 percent of the time (data not shown). Combined, these facts suggest Medicaid insurers serve as an imperfect proxy for a lower-cost public option–type competitor. We now turn to analyzing how non-Medicaid insurers' premiums relate to the presence of a competing Medicaid insurer.

Table 3 shows the average lowest marketplace silver premium in 2019 for non-Medicaid insurers nationwide, along with the average values for each explanatory variable we control for in our analysis. The averages are not weighted because we do not have enrollment information by insurer. The average monthly lowest silver premium across non-Medicaid insurers is $534.16 in 2019. Approximately 40 percent of non-Medicaid insurers offering marketplace coverage (insurers counted separately for each rating region they participate in) compete with at least one Medicaid insurer in 2019. Slightly less than two-thirds of these insurers offer coverage in an urban rating area. Approximately 12 percent of non-Medicaid marketplace insurance offerings are in the most competitive hospital markets (HHI of 2,500 or lower), and about 36 percent are in the least competitive hospital markets (HHI from 7,501 to 10,000). Non-Medicaid insurers competing with Medicaid insurers are more likely to be in rating regions with five or more competing insurers than are those without Medicaid insurer competition. About three-quarters of non-Medicaid insurer offerings are in federally facilitated marketplace states.

The key finding is that the presence of at least one Medicaid insurer in a marketplace rating region is associated with lower premiums offered by non-Medicaid insurers (Table 4). These results imply that if a Medicaid insurer provides competition, other plans' lowest silver premiums are, on average, about $38 per month lower; this represents a 7.1 percent reduction relative to the average for all non-Medicaid insurers of $534. Unsurprisingly, premiums in the rating regions with pure community rating (Vermont and New York) tend to be significantly higher than premiums for a 40-year-old in other states, because the premiums are the same for all enrollees in a given geographic area and represent an average across all enrollees. Premiums in urban areas tend to be lower by about $35 per month, on average, for an insurer's lowest

silver offering. The relationship between the HHI variable for insurers in the least competitive hospital markets (HHIs between 7,500 and 10,000) and non-Medicaid insurer premiums is statistically significant and indicates premiums in this area are, on average, $41 per month higher than those in the most competitive hospital markets, or about 7.7 percent higher than the average premium.

The relationship between non-Medicaid insurers' lowest premiums and the number of competing insurers is less direct and monotonic than the relationship between rating region benchmark premiums and the number of competing insurers. Non-Medicaid insurer premiums are significantly higher in rating regions with two competing insurers than in rating regions with five or more, however. The average wage index is also statistically significant, with premiums tending to be higher in higher-wage areas, as one would expect. Non-Medicaid insurers' premiums in states that have expanded Medicaid eligibility are, on average, about $57 per month lower, and insurers in states using the federally facilitated marketplace tend to have higher premiums than similarly situated insurers in state-based marketplaces.

CONCLUSION

Our analysis finds an association between the presence of a Medicaid insurer in a rating region and competing insurers (e.g., Blue Cross Blue Shield, provider-sponsored plans, national and local commercial insurers) offering lower premiums. Though we do not suggest our models are sufficiently comprehensive to assess whether the relationship between Medicaid insurer presence and non-Medicaid insurer premiums is causal, our results suggest a causal relationship. This is because we control for hospital market concentration and average wages, allowing us to show that non-Medicaid insurers' lower premiums in rating regions with a Medicaid insurer are not simply the consequence of Medicaid insurers choosing to participate in lower-cost areas. In addition, Medicaid insurers could simply be entering noncompetitive insurance markets, where it is easier to underprice existing monopolists or duopolists. However, as shown in Table 1, rating regions with at least one participating Medicaid insurer are substantially more likely to have four or more competing insurers than rating regions without Medicaid insurers. This indicates Medicaid insurers are frequently willing to compete in otherwise competitive markets. Taken together, our findings provide early evidence that lower-cost insurers, like public options, may catalyze competitive responses from other insurers, lowering overall average premiums in a market. However, it is possible that there are other unmeasured characteristics of health care markets that make them less attractive to MCOs and that could be correlated with premiums for non-Medicaid insurers. It is also possible that Medicaid MCOs are able to negotiate the best provider payment rates to marketplace enrollees in areas where they also offer coverage through the Medicaid program, an area worth exploring further.

If the relationships is indeed causal—meaning competing Medicaid insurers lead to lower premiums among other marketplace insurers—introducing a public option into a rating region without significant competition (i.e., those that do not already have Medicaid insurers participating in the marketplaces) should lead to larger premium savings than those generated by the public option alone. The direct effect is that the public option would offer a premium likely significantly below commercial insurers' premiums in a noncompetitive area; that is likely to be the largest effect in those rating regions. The indirect effect is that private insurers can also be expected to lower their premiums in response, as estimated here, additional but likely smaller savings than those of the direct effect.

Table 1. Means for Premium-Level Regression Model, at the Rating Region Level

Variable	Mean	Mean in Rating Regions with Medicaid Insurers in Marketplace	Mean in Rating Regions with No Medicaid Insurers in Marketplace
N	**502**	**202**	**300**
Dependent variable			
2019 benchmark premium	$517.73	$443.28	$567.86
Independent variables			
Rating region is in an urban area	0.606	0.694	0.545
Blue Cross Blue Shield insurer participates in rating region marketplace	0.826	0.718	0.900
Medicaid insurer participates in rating region marketplace	0.406	1	0
National insurer participates in rating region marketplace	0.049	0.073	0.033
Provider insurer participates in rating region marketplace	0.252	0.252	0.252
Regional insurer participates in rating region marketplace	0.373	0.383	0.365
Co-op insurer participates in rating region marketplace	0.055	0.044	0.063
One marketplace insurer in rating region	0.325	0.068	0.502
Two marketplace insurers in rating region	0.312	0.330	0.299
Three marketplace insurers in rating region	0.176	0.262	0.116
Four marketplace insurers in rating region	0.110	0.199	0.050
Five or more marketplace insurers in rating region	0.077	0.141	0.033
Rating region is in South census region	0.503	0.432	0.551
Rating region is in Northeast census region	0.079	0.058	0.093
Rating region is in West census region	0.166	0.204	0.140
Rating region is in Midwest census region	0.252	0.306	0.216
Rating region is in state that expanded Medicaid by 2018	0.458	0.597	0.362
Rating region is in a state with community rating	0.018	0.039	0.003
Rating region population in 2019	648,812.9	1,005,916	408,363
Average wage index	0.906	0.940	0.883
Rating region hospital HHI between 0 and 2,500	0.079	0.150	0.030
Rating region hospital HHI between 2,501 and 5,000	0.179	0.248	0.133
Rating region hospital HHI between 5,001 and 7,500	0.285	0.277	0.292
Rating region hospital HHI between 7,501 and 10,000	0.457	0.325	0.545
Federally facilitated marketplace state	0.827	0.820	0.834

Sources: Premium data are from the Healthcare.gov Public Use File for the 2019 plan year and from individual state-based marketplace websites. Other sources include the American Hospital Association and the Centers for Medicare & Medicaid Services.

Note: HHI = Herfindahl-Hirschman Index.

Table 2. Regression Coefficients: Dependent Variable Is Benchmark Premium in Each Rating Region in 2019

	Coefficients
Medicaid insurer participates in rating region marketplace	-29.86*
Blue Cross Blue Shield insurer participates in rating region marketplace	72.43***
National insurer participates in rating region marketplace	27.55
Provider insurer participates in rating region marketplace	53.87***
Regional insurer participates in rating region marketplace	54.55***
Co-op insurer participates in rating region marketplace	5.78
Rating region is in an urban area	-29.85***
One marketplace insurer in rating region	230.54***
Two marketplace insurers in rating region	133.60***
Three marketplace insurers in rating region	60.86***
Four marketplace insurers in rating region	57.48***
Rating region is in South census region	-35.85**
Rating region is in Northeast census region	-24.53
Rating region is in West census region	55.94***
Rating region is in state that expanded Medicaid by 2018	-62.91***
Rating region is in a state with community rating	218.90***
Rating region population in 2019	-2.74E-06
Average wage index	40.19**
Rating region hospital HHI between 2,501 and 5,000	-18.36
Rating region hospital HHI between 5,001 and 7,500	-18.42
Rating region hospital HHI between 7,501 and 10,000	-6.37
Rating region is in a federally facilitated marketplace state	90.50***
Intercept	**259.95*** **
R^2	**0.54**
N	**502**

Sources: Premium data are from the Healthcare.gov Public Use File for the 2019 plan year and from individual state-based marketplace websites. Other sources include the American Hospital Association and the Centers for Medicare & Medicaid Services.

Notes: HHI = Herfindahl-Hirschman Index.

//*** indicates coefficient is significant at the 0.10/0.05/0.01 level.*

Table 3. Means for Premium-Level Regression Model, at the Insurer Level (Non-Medicaid Only)

Variable	Mean	Mean in Rating Regions with Medicaid Insurers in Marketplace	Mean in Rating Regions with No Medicaid Insurers in Marketplace
N	**922**	**370**	**552**
Dependent variable			
2019 lowest-cost silver premium offered in marketplace by each non-Medicaid insurer	$534.16	$503.82	$554.50
Independent variables			
Medicaid insurer participates in rating region marketplace in 2019	0.401	1	0
Plan is in a state with community rating	0.025	0.059	0.002
Rating region population	833,967.1	1,259,008	549,581.9
Plan is in an urban rating region	0.639	0.762	0.557
Plan is in a rating region with hospital HHI between 0 and 2,500	0.115	0.208	0.052
Plan is in a rating region with hospital HHI between 2,501 and 5,000	0.206	0.284	0.154
Plan is in a rating region with hospital HHI between 5,001 and 7,500	0.322	0.268	0.358
Plan is in a rating region with hospital HHI between 7,501 and 10,000	0.358	0.241	0.436
One marketplace insurer in rating region	0.161	0	0.269
Two marketplace insurers in rating region	0.281	0.181	0.347
Three marketplace insurers in rating region	0.232	0.300	0.186
Four marketplace insurers in rating region	0.168	0.259	0.107
Five or more marketplace insurers in rating region	0.158	0.259	0.090
Average wage index	0.943	0.974	0.923
Plan is in a federally facilitated marketplace state	0.748	0.768	0.734
Plan is in a state that expanded Medicaid by 2018	0.542	0.624	0.486
Plan is in Northeast census region	0.124	0.086	0.148
Plan is in South census region	0.389	0.381	0.394
Plan is in West census region	0.215	0.230	0.204
Plan is in Midwest census region	0.273	0.303	0.253

Sources: Premium data are from the Healthcare.gov Public Use File for the 2019 plan year and from individual state-based marketplace websites. Other sources include the American Hospital Association and the Centers for Medicare & Medicaid Services.

Note: HHI = Herfindahl-Hirschman Index.

Table 4. Regression Coefficients: Dependent Variable Is Lowest-Cost Silver Premium for Each Non-Medicaid Insurer in Every Rating Region in 2019

	Coefficients
Medicaid insurer participates in rating region	-38.14***
Plan is in a state with pure community rating	277.1***
Rating region population	-1.86e-06
Plan is in an urban rating region	-34.95***
Plan is in a rating region with hospital HHI between 2,501 and 5,000	10.92
Plan is in a rating region with hospital HHI between 5,001 and 7,500	27.73**
Plan is in a rating region with hospital HHI between 7,501 and 10,000	40.97***
One marketplace insurer participates in rating region	22.23
Two marketplace insurers participate in rating region	30.27**
Three marketplace insurers participate in rating region	-11.32
Four marketplace insurers participate in rating region	-2.52
Average wage index	110.51***
Plan is in a state that expanded Medicaid by 2018	-56.62***
Plan is in a federally facilitated marketplace state	53.36***
Plan is in South census region	3.92
Plan is in Northeast census region	-25.11*
Plan is in West census region	34.51***
Intercept	**412.18*** **
R^2	**0.28**
N	**922**

Sources: Premium data are from the Healthcare.gov Public Use File for the 2019 plan year and from individual state-based marketplace websites. Other sources include the American Hospital Association and the Centers for Medicare and Medicaid Services.

Notes: HHI = Herfindahl-Hirschman Index.

//*** indicates that coefficient is significant at the 0.10/0.05/0.01 level.*

NOTES

1. Blumberg LJ, Holahan J. Designing a Medicare buy-in and a public plan marketplace option: Options and considerations. Urban Institute. 2012. https://www.urban.org/research/publication/designing-medicare-buy-and-public-plan-marketplace-option-policy-options-and-considerations. Published September 28, 2016. Accessed September 5, 2019.
2. Holahan J, Blumberg LJ, Wengle E, Elmendorf C. What's behind 2018 and 2019 marketplace insurer participation and pricing decisions? Urban Institute. 2019. https://www.urban.org/research/publication/whats-behind-2018-and-2019-marketplace-insurer-participation-and-pricing-decisions. Published January 24, 2019. Accessed September 5, 2019.
3. Wengle E, Blumberg LJ, Holahan J. Are marketplace premiums higher in rural than in urban areas? Urban Institute. 2018. https://www.urban.org/research/publication/are-marketplace-premiums-higher-rural-urban-areas. Published November 14, 2018. Accessed September 5, 2019.
4. In 2019, 60 rating areas have HHIs below 2,500; 89 have HHIs from 2,501 to 5,000; 148 have HHIs from 5,001 to 7,500; and 205 have HHIs from 7,501 to 10,000.
5. Holahan J, Blumberg LJ, Wengle E, Solleveld P. What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary across the Country? Washington: Urban Institute; 2017. https://www.urban.org/research/publication/what-explains-21-percent-increase-2017-marketplace-premiums-and-why-do-increases-vary-across-country. Published January 11, 2017. Accessed September 5, 2019.
6. The averages in Table 1 are unweighted.

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About the Authors and Acknowledgments

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